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01 June 2010

Version of attached file:

Accepted Version

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

Bambra, C. (2010) 'Yesterday once more ? unemployment and health in the 21st century.', Journal of epidemiology and community health., 64 (3). pp. 213-215.

Further information on publisher's website:

<http://dx.doi.org/10.1136/jech.2009.090621>

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This article has been accepted for publication in Journal of Epidemiology and Community Health (JECH). The definitive copyedited, typeset version, Bambra, C. (2010) 'Yesterday once more ? unemployment and health in the 21st century.', Journal of epidemiology and community health., 64 (3). pp. 213-215 is available online at : <http://jech.bmj.com>

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Yesterday once more? Unemployment and health in the 21st century.

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Article word count = 2040 words

Abstract

The relationship between economic recession, higher unemployment and poorer health is well established in the medical and social science research literature. Much of this research resulted from the last major economic recessions of the early 1980s and 1990s. Many parallels are being made between then and now. This paper therefore revisits this literature to ascertain what the unemployment consequences of the economic recession may mean for public health and health services. However, this research agenda paper also outlines key differences between then and now focusing on the structure of the welfare system, and the organisation and experience of work. It is therefore, not simply a case of 'yesterday once more' and public health research, policy and practice needs to be sensitive and responsive to these changes.

124 words

INTRODUCTION

The relationship between economic recession, higher unemployment and poorer health and wellbeing is well established in the medical, epidemiological and social science research literature.¹ Much of this research resulted from the last major economic recessions of the early 1980s and 1990s.² Many parallels are being made between the current economic crisis and previous ones, not least in terms of the economic, social and health effects of rising unemployment (expected to rise to around 8.5% in the UK and the USA and 10% in France during 2009).^{3,4} It therefore seems timely to revisit this literature in order to ascertain what the unemployment consequences of the economic recession may mean for public health and health services. However, this research agenda paper also outlines key differences between then and now which may be important in terms of fully understanding how unemployment and its health effects are experienced in the changed labour market context of the 21st century.

UNEMPLOYMENT AND HEALTH

Unemployment is associated with an increased likelihood of morbidity and mortality.¹ There are clear relationships between unemployment and increased risk of poor mental health and parasuicide,^{5,6} higher rates of all cause and specific causes of mortality,^{7,8} self reported health and limiting long term illness,⁹ and, in some studies, a higher prevalence of risky health behaviours (particularly amongst young men), including problematic alcohol use and smoking.¹⁰ The negative health experiences of unemployment are not limited to the unemployed only but also extend to families and the wider community.^{11,12} For example, figures from a 1984 study suggested that for every *“2000 men seeking work 2 (1.94), and among their wives 1 (0.98), will die each year as a result of unemployment”*.¹³ Unemployment therefore has serious implications for health service planning with, for example, increased pressures on mental health services.¹⁴

Links between unemployment and poorer health have conventionally been explained through two inter-related concepts: the material consequences of unemployment (e.g. wage loss and resulting changes in access to essential goods and services), and the psychosocial effects of unemployment (e.g. stigma, isolation and loss of self-worth).¹⁴ Research has also drawn

attention to the contributory role of ill health itself as a factor behind unemployment (health selection) and this will probably be attenuated in times of economic hardship. Ill health related job loss also has a social gradient, with adverse employment consequences more likely for those in lower socio-economic groups.^{15 16} These older studies have tended to suggest that the negative relationship between unemployment and health is stronger for men than women.¹⁷

The current research literature therefore suggests that the increased unemployment resulting from the current economic recession will have negative public health effects and a corresponding increase in the use of health services. However, significant changes in the constitution of economic life mean that the magnitude of the unemployment related health effects of this recession may be under estimated if we rely solely upon research data from the recessions of previous eras. Key differences between then and now include the structure of the welfare system, and the organisation and experience of work. It is therefore, not simply a case of 'yesterday once more' and public health research needs to be sensitive to these changes if the contemporary health consequences of unemployment are to be fully understood.

WELFARE SYSTEM

The welfare systems of most developed economies have experienced considerable reform since the last two economic recessions. This has meant that access and entitlement to out of work cash benefits and welfare services have decreased considerably. For example, the population coverage of unemployment benefit in the UK decreased from 90% in 1980 to 77% in 1999, in Germany it decreased from 100% to 84% and in Norway, from 100% to 79%.¹⁸ The replacement value of unemployment benefit has also decreased in the UK from 45% of average wages in 1980 to just 16% in 1999; in Germany it decreased from 68% to 37%, and in Norway from 70% to 62%.¹⁸ The welfare safety net for women is often smaller than that for men.¹⁷ The extent to which the welfare state can act as a buffer against the negative social and health consequences of economic recession has therefore been diminished.

Further, there is an increased use of welfare to work policies, requiring the unemployed to partake in compulsory employability and skills training in order to receive benefits.¹⁹ The likely success of such schemes in returning people to employment seems limited within a contracting labour market. In fact, from a health perspective, they may well be counter productive in terms of their stigmatising effects and the division of the poor into deserving and undeserving.²⁰ Certainly, an Australian study of welfare to work schemes amongst young people in the 1990s found them to be almost as detrimental to mental health as unemployment.²¹ Indeed, the economic recession and the resulting rise in unemployment have not put a stop to the continued individualisation of responsibility for unemployment or indeed, for poor health. Previous recessions suggest that the stigmatising of benefit recipients, particularly in the UK, Australia and the USA, as scroungers will only increase.²² This has meant that although unemployment benefit has long been characterised by stigma and means-testing,^{22 23} the cash benefits now provided to people when they are out of work are of considerably less value in real terms than they used to be and a lot more is required in order to be entitled to them. Given the links between material poverty and poor health, and between social stigma and poor health, this may have important negative influences on the relative health of the unemployed.^{1 14} This may increase health inequalities between those with and without work.²⁴

It is also important to note that this “new” unemployment coexists with structural worklessness in the form of long term sickness absence and disability pension receipt. Across Europe, disability pension receipt has increased significantly over the past 25 years and in some post-industrial areas of Europe rates are as high as 18% of the working age population.²⁵ The vast majority of new disability claims are on the basis of mental health. Mental health problems also develop as co-morbidities amongst those who are initially out of the labour market due to chronic physical health problems (such as musculoskeletal conditions).²⁶ It therefore seems likely that the new wave of unemployment will also impact on mental health more than on physical health. This will certainly be the case initially, as most previous studies have noted a lag in terms of the physical health effects of unemployment of up to 2 years.^{27 28} It is possible that the coexistence of high levels of health and disability related worklessness may actually

decrease the stigma attached to unemployment as worklessness of various forms becomes “normalised” within certain deprived post-industrial communities. As Orwell commented in *The Road to Wigan Pier* (1937[1981]: 78), “when people live on the dole for years at a time they grow used to it, and ... though it remains unpleasant, it ceases to be shameful ... It makes a great deal of difference when things are the same for everybody”.²³ This will not of course decrease the health effects of the material deprivation experienced by unemployed individuals and workless communities. Further, the social exclusion of workless communities (as opposed to unemployed individuals within them) may well increase in the longer term and lead to the further stigmatisation of such places with resulting rises in geographic inequalities in health and economic development.

WORLD OF WORK

Work itself has long been acknowledged as an important social determinant of health and health inequalities.²⁹ The quality and type of employment are vital in terms of income and social status in all advanced industrialised societies. Work also dominates adult life. However, the nature of work has altered considerably in the UK, Northern America, Japan and Europe over the past two decades, with a decrease in industrial employment and an increase in the size of the service sector (e.g. in the UK, the manufacturing sector’s share of GDP has declined by nearly 50% over the last 25 years). A 24 hour society has also started to emerge with the increased use of shift work. This has led to public health concerns about abnormal working hours and work-life balance.³⁰ This has also been accompanied by a decline in the number of standard full-time, permanent jobs and a rise in flexible – precarious – employment: increasing numbers of people are working on either temporary contracts or no contracts, with limited or no employment or welfare rights. There is a negative relationship between precarious, insecure employment and health.^{1 31}

Simultaneously, women’s employment rates have also substantially increased in most Western economies (e.g. in the UK they have increased from 56% in 1971 to 70% in 2007). Previous research suggested that the health effects of unemployment were greater for men than for women. Explanations of this were based on the vital importance of paid work for male

self-identity^{22 23} and/or the fact that men are less likely to seek health and social support.⁴ In contrast, women's traditional social roles (notably motherhood or homemaking) acted as buffers to the mental health effects of job loss as they gave alternative sources of identity. As the labour market is becoming increasingly feminised and gender roles shift, this might no longer be the case (if indeed it ever was) as work becomes an increasingly important part of most women's self-identity. This time, the negative health effects of unemployment may be more equally experienced by women as by men. This will increase the demands on health services.

These new economic forms will also impact on the experience and distribution of unemployment as those with the least protection will be at most risk of unemployment, often without redundancy packages. These are likely to be women, the young, and immigrants – the “reserve army of labour”. These are also the workers who have the least entitlement to public welfare benefits. They are also less likely to have community based social support. Further, workers currently experiencing a daily existence of low paid, high-strain, temporary employment, may be ill prepared for, and least resilient to, the additional negative health premium of unemployment. So in such cases, whilst unemployment may temporarily release people from the negative health effects of insecure employment, it does not provide an adequate safety net to be a healthy alternative. Those remaining in the workplace will also be subject to more psychosocial stress from increased job insecurity and increased likelihood of redundancy.¹

CONCLUSION

This brief analysis suggests that there are at least four key differences between unemployment then and now: (1) the safety net available to the unemployed is less than in previous recessions although benefit receipt is more stigmatised; (2) in some areas, the “new” unemployment co-exists with significant structural worklessness in the form of disability pension receipt; (3) the changed work environment, the deterioration of employment rights, and the decrease in social support, suggests that unemployment may have an additional relative health burden for some than in the past; and (4), as a recent pan-European study

shows, women's unemployment is likely to become a greater public health issue than in the past.¹⁷ Depending on the length and depth of the current recession (which is unknown), this suggests that the negative health consequences of unemployment are likely to be wider and greater than in the past. Based on previous research, in the short term we can expect increased mental health problems amongst the unemployed of both genders, their children, and the wider community.^{11 12} Longer term, it is likely that physical health problems, including mortality, will also increase.^{27 28} This will have important consequences in terms of public health research and practice, as well as in terms of political discussions of unemployment.^{4 14} Research on unemployment needs to be more sensitive to this changed context by, for example, examining more closely women's experiences of unemployment. Similarly, the employment and rehabilitation services provided by public agencies will need to be increased and they may also need to be more gender sensitive and gender specific than they have in the past.³² We also need to be aware of the health effects of such interventions and so education should be favoured over welfare to work programmes.⁴ Most notably, policy interventions need to break the relationship between unemployment and poor health for everyone.

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